CHRONIC DISEASE RISK REDUCTION
REQUEST FOR PROPOSALS

Background

The mission of the Chronic Disease Risk Reduction community grant program is to address chronic disease risk reduction through evidenced-based based strategies that impact tobacco use, physical activity and nutrition. Chronic diseases account for roughly 75 percent of health care costs each year.[1] Based on national estimates in 2010, nearly $20 billion was spent in Kansas on chronic disease.[2] As states struggle to meet the staggering costs of health care, the most cost-effective interventions are frequently overlooked. Impressive achievements in population health are possible by reducing the prevalence of risk factors that underlie chronic disease and injury and by helping people actively manage their chronic conditions.
CDRR workplans must demonstrate how health equity will be addressed in the applicant community.

SOCIAL DETERMINANTS OF HEALTH - Many chronic conditions tend to be more common, diagnosed later, and result in worse outcomes for particular individuals, such as people of color, people in low-income neighborhoods, and others whose life condition place them at risk for poor health. https://www.ncbi.nlm.nih.gov/books/NBK25526/ While health disparities can be addressed at multiple levels, the Chronic Disease Risk Reduction program focuses on policy, systems, and environmental strategies designed to improve the places where people live, learn, work, and play, i.e. social determinants of health.

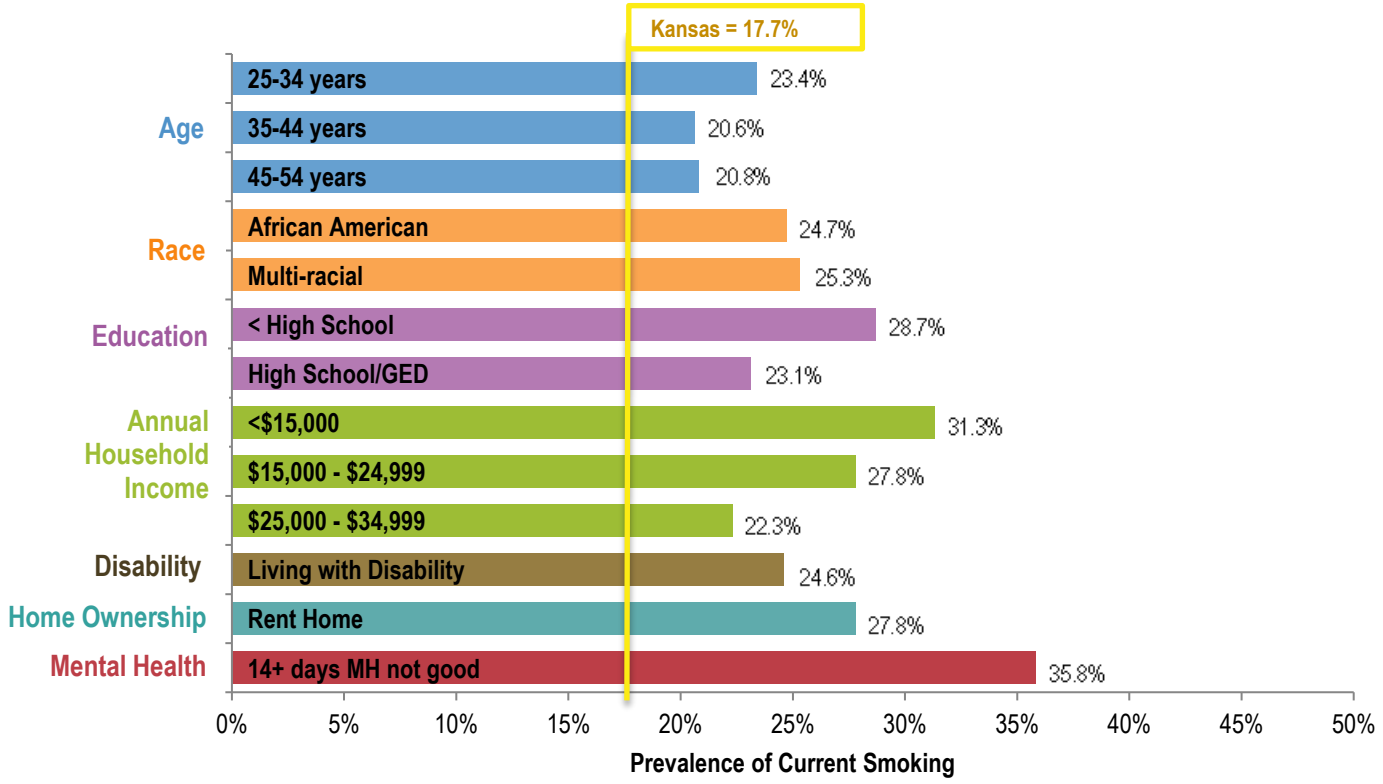
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.[3]

Health disparities in around tobacco use and obesity
TOBACCO USE - Tobacco use is the leading cause of preventable death and disease in Kansas. Annually, cigarette use alone causes approximately 4,400 deaths in Kansas, costing more than $1.12 billion in medical expenditures and $1.09 billion in lost productivity from an experienced workforce that dies prematurely.[4] The prevalence of smoking among adults age 18 and older has declined significantly in Kansas from 22.0 percent in 2011 to 17.7 percent in 2015.[5] Despite overall declines in cigarette smoking some population groups have disportionately higher rates of smoking. For example, about three in ten adults with an annual household income of less than $15,000 smoke compared to about one in ten adults with an annual household income of $50,000 or more.[5] The prevalence of exposure to secondhand smoke at home and in private vehicles is also higher among adults with lower household incomes.[6] Figure 1 displays the prevalence of current smoking by annual household income, for those income categories with a prevalence that is higher than the overall Kansas

[1] The Power to Prevent, Call to Control: At A Glance 2009. Centers for Disease Control and Prevention website. 2009. Available at: www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm. Accessed December 14, 2012.
[2] U.S. Health Care Costs. Kaiser Family Foundation, Kaiser EDU website. 2012. Available at http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx#footnote/. Accessed December 17, 2012.
[3] Healthy People 2020, accessed November 1, 2016, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[4] Campgain for Tobacco Free Kids, November 1, 2016, http://www.tobaccofreekids.org/facts_issues/toll_us/kansas..
[5] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.
[6] 2014 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

state prevalence.[7] Also shown are smoking disparities by age, race, education, living with a disability, home ownership and mental health status.

Figure 1: Current cigarette smoking among Kansas adults varies by age, race, education, income, living with a disability, homeownership and mental health status (2015 KS BRFSS[7])



Although smoking prevalence does not differ by population density in Kansas, there is substantial geographic variation. County prevalence rates of current smoking among adults vary from a low of 12.6 percent to a high of 45.6 percent and regional estimates vary from 16.1 percent to 28.4 percent.[8]

Despite the substantial disparities, 55.1 percent of current smokers in Kansas tried to quit smoking in the past year and members of sub-populations disproportionately impacted by tobacco use are equally interested in quitting. Additionally, youth continue to use tobacco at an alarming rate. Data from the 2013 Kansas Youth Risk Behavior Survey (KYRBS) reveal that 10.2 percent of high school students reported using cigarettes.[9] The 2013 KYRBS also indicates that 13.2 percent of high school male students in Kansas currently use smokeless tobacco.

The Centers for Disease Control and Prevention has resources that provide information and examples that may be useful in reducing health disparities and advancing health equity in tobacco control. *Health Equity in Tobacco Prevention and Control* and *A Practitioner's Guide for Advancing Health Equity*, and *Community Strategies for Preventing Chronic Disease Tobacco Free Living Strategies*

[7] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.
[8] 2013 Kansas Behavioral Risk Factor Surveillance System. Kansas Depart2014 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.ment of Health and Environment, Bureau of Health Promotion.
[9] 2013 Kansas Youth Risk Behavior Survey. Kansas State Department of Education.

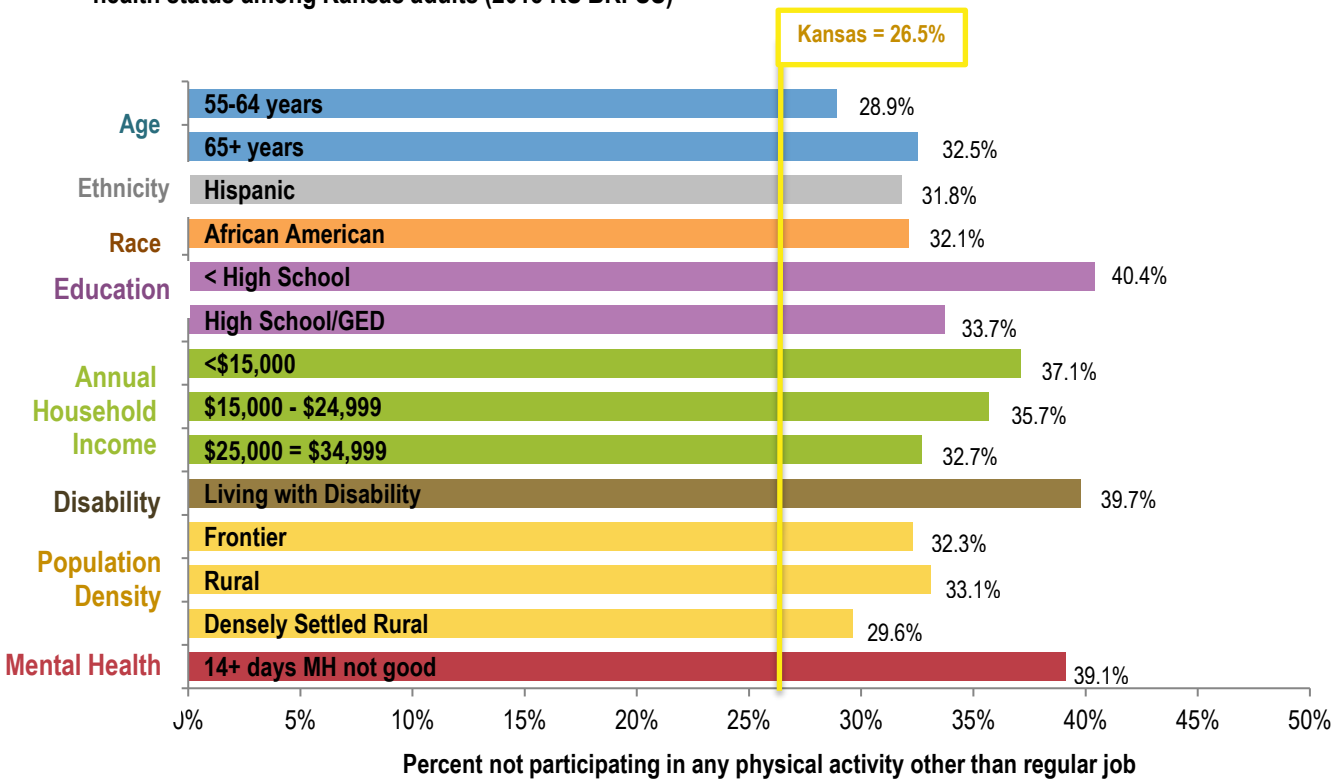
OBESITY- Obesity, defined as a body mass index (BMI) greater than 30 kg/m^2, increases the risk for several chronic diseases including coronary heart disease, type 2 diabetes, certain cancers, stroke and osteoarthritis.[10] The prevalence of obesity increased significantly in 2015. Currently more than one in three Kansas adults age 18 years and older is obese (34.2 percent).[11] As with tobacco use, there are specific sub-populations in Kansas who are disproportionately impacted by obesity. The percentage of Kansas adults who are obese is significantly higher among Kansans age 35 to 64 years, persons with lower annual household incomes, lower educational levels, and those living with a disability or with poor mental health status. Obesity prevalence is also higher among African Americans and those of Hispanic ethnicity. In 2013, 28.9 percent of Kansas high school students in grades 9-12 were overweight or obese (16.3% overweight, 12.6% obese.)[4]

PHYSICAL ACTIVITY - Regular physical activity is associated with reduced risk of several chronic health conditions including coronary heart disease, stroke, type 2 diabetes and certain cancers.[12] Participating in physical activity also delays the onset of functional limitations,[13] prevents obesity[10] and is essential for normal joint health.[14] The U.S. Department of Health and Human Services' *2008 Physical Activity Guidelines for Americans* recommend that adults participate in at least 150 minutes a week of moderate-intensity aerobic activity, or 75 minutes a week of vigorous-intensity aerobic activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. The *Guidelines* also recommend that children and adolescents participate in at least 60 minutes of physical activity per day.

In 2015, 80.7 percent of Kansas adults 18 years and older did not meet these physical activity guidelines and 26.5 percent of Kansas adults did not participate in any physical activity other than their regular job during the past month.[15] Figure 2 shows disparities in the percentage of Kansas adults that did not participate in any physical activity other than their regular job. Disparities exist by age, ethnicity, race, education, income, population density, living with a disability and mental health. The majority of these disparities occur in the same populations that are disproportionately impacted by obesity. Kansas adults who have lower education, lower annual household incomes, are living with a disability or have poor mental health status have higher prevalence of obesity and a greater percentage who do not participate in any physical activity other than their regular job. The same is true for Kansas adults of Hispanice ethnicity and African American race. In 2013, 71.7 percent of Kansas high school students in grades 9-12 did not engage in recommended levels of physical activity (i.e. at least 60 minutes per day).[16]

[10] U.S. Department of Health and Human Services. Public Health Service; National Institutes of Health; National Heart, Lung and Blood Institute. Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults. NIH Publication No. 98-4083; 1998.
[11] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.
[12] U.S. Department of Health and Human Services. *2008 Physical Activity Guidelines for Americans.*
[13] Huang Y, Macera CA, Blair SN, Brill PA, Kohl HW, Kronfeld JJ. Physical fitness, physical activity, and functional limitations in adults 40 and older. *Medicine Science in Sports and Exercise.* 1998;30:1430-1435.
[14] Minor MA. Exercise in the treatment of osteoarthritis. *Rheum Dis Clin North Am.* 1999;25:397-415.
[15] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.
[16] 2013 Kansas Youth Risk Behavior Survey, Kansas State Department of Education.

Figure 2: Physical acitivity varies by gender, age, education, income, living with a disability, and mental health status among Kansas adults (2015 KS BRFSS)

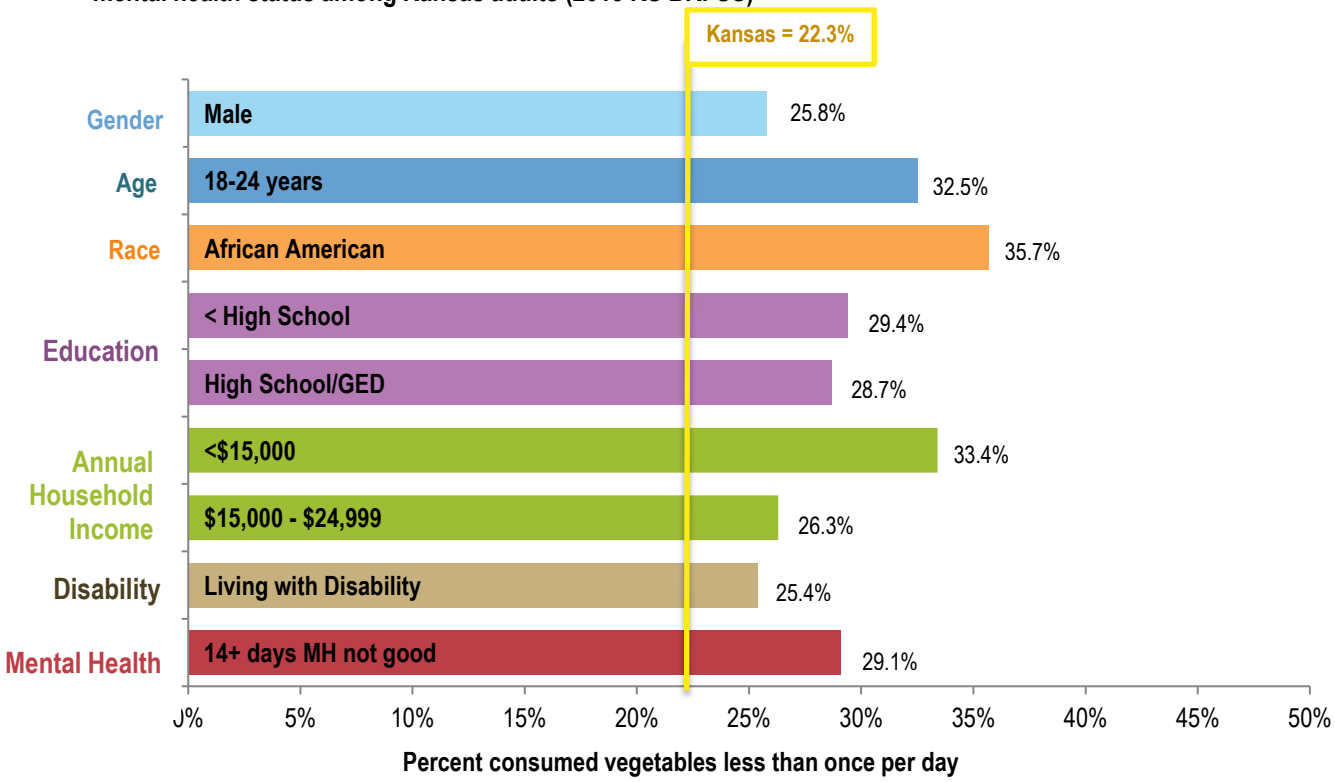


NUTRITION - Research shows that eating at least two and a half cups of fruits and vegetables per day is associated with a reduced risk of many chronic diseases, including cardiovascular disease and hypertension . A diet rich in fruits and vegetables can also help adults and children achieve and maintain a healthy weight.[17] In 2015, one in five Kansas adults 18 years and older (22.3 percent) consumed vegetables less than 1 time per day.[17] The percentage of Kansas adults who consumed vegetables less than 1 time per day was significantly higher among males, adults age 18-24 years, African Americans, and those with lower education, lower annual household income, living with a disability or poor mental health. [18]15 These disparities are displayed in Figure 3 below. An even greater number of Kansans do not consume fruits. In 2015 43.7 percent of Kansas adults consumed fruit less than 1 time per day. Some of sub-populations with significantly lower fruit consumption are similar to those noted for vegetable consumption. The percentage of adults who did not consume fruit at least once per day is significantly higher among males, adults age 18 to 24 years, and among those with lower education, annual household incomes of less than $15,00, living with a disability and poor mental health status. In 2013, only 16.4 percent of Kansas high school students in grades 9-12 ate fruits and vegetables five or more times per day.[16]

[17] U.S. Department of Agriculture and U.S. Department of Health and Human Services. *Dietary Guidelines for Americans, 2010*. 7th Edition, Washington, DC: U.S. Government Printing Office;2010.

[18] 2015 Kansas Behavioral Risk Factor Surveillance System. Kansas Department of Health and Environment, Bureau of Health Promotion.

Figure 3: Vegetable consumption varies by gender, age, education, income, living with a disability, and mental health status among Kansas adults (2015 KS BRFSS)



CHRONIC DISEASE SELF-MANAGEMENT EDUCATION: Chronic Disease Self-Management Education (CDSME) programs are evidence-based classes with curriculum developed by Stanford University to improve the quality of life of those living with chronic disease.[19] The program specifically addresses arthritis, diabetes and lung and heart disease, but teaches skills useful for managing a variety of chronic diseases. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshop participation is recommended for anyone living with one or more chronic conditions, family and friends of those living with a chronic condition and caregivers. These interactive workshops provide participants with techniques to deal with problems associated with chronic disease, nutrition, appropriate exercise, appropriate use of medications, communicating effectively with family, friends and health professionals and how to evaluate new treatments. Participants also learn and practice problem-solving and action planning.

[19] http://patienteducation.stanford.edu/programs/cdsmp.html

The purpose of this grant program is to provide funding and technical assistance to communities to address chronic disease risk reduction through evidence-based strategies and best practices that impact tobacco use, physical activity, nutrition and chronic disease self-management.

All applications must address tobacco, while work in physical activity, nutrition and CDSME is optional. This document provides background and guidelines for developing a full proposal and submission instructions. This is a competitive grant process, meaning that grants will be awarded based upon the quality and clarity of the proposed activities and achievability of proposed outcomes. Applications will be scored based on adherence to guidelines. Application instructions are included in this document.

The grant program is structured to promote community program progress in two distinct phases:

1. ***Planning and Capacity (1 year maximum):*** appropriate for applicants who lack a functioning chronic disease control coalition and/or lack a recent community assessment upon which they can plan and justify CDRR activities. At least 0.25 full-time equivalent (FTE) (a minimum of 10 hours per week) must be dedicated to grant implementation. Planning applicants may propose community interventions in their application.

   Planning and Capacity Phase Deliverables:

   - Complete an approved community-wide and/or targeted assessment tool
   - Establish a functional chronic disease prevention coalition including at a minimum a tobacco committee or sub-committee focused on tobacco
   - Develop a plan guided by community and/or targeted assessment results
   - 0.25 FTE minimum – at least 10 hours/week staffing must be dedicated to this grant
   - 25 percent local match

2. ***Implementation:*** applicants with a functioning coalition and a community-wide or targeted assessments completed within the past five years should apply at the implementation level. Grant funds support local tobacco control, physical activity, nutrition and chronic disease self-management programming, participation in the county and state level youth surveillance as requested.

   Implementation Phase Deliverables:

   - Maintain a functional chronic disease prevention coalition including at a minimum a tobacco committee or sub-committee focused on tobacco
   - 0.25 FTE minimum – at least 10 hours/week staffing must be dedicated to this grant
   - 25 percent local match

GRANTEE REQUIREMENTS (if awarded):

Progress made towards requirements will be entered into the Catalyst data system after grant year begins.

<u>Administration and Management</u>

1. Participate in CDRR technical assistance and professional development opportunities.

2. Host one mid-year Community Health Specialist site visit by December 30 and participate in bi-monthly progress calls.
3. Report progress in Catalyst at the workplan level at least 5 days prior to bi-monthly calls and site visits and at mid-year (due Jan. 15) and year-end (due July 15). Where applicable, progress should include a description of how underserved populations are engaged and reached.
4. Submit all communications items (including legislative letters and other media) to Community Health Specialist for review at least two weeks prior to date needed.
5. Upload agenda and meeting minutes to Catalyst after each coalition meeting.
6. Submit surveys to KDHE epidemiologist for review at least two weeks in advance of survey administration.

Data and Information Activities

1. Complete a community assessment if most recent community assessment is five or more years old. Consult with regional Community Health Specialist and Community Health Promotion Epidemiologist to identify appropriate sources of existing data, assessment tools and community partners. Existing data should be used to describe the burden of diseases and risk factors in the community. Qualitative information from focus groups, neighborhood conversations, and key informant interviews, as well special surveys, can provide supplemental information regarding opinon type questions, neighborhood context, and community priorities. Below are a sample of existing data sources that should be consulted:
    a. Kansas Behavioral Risk Factor Surveillance System (including county and regional estimates): http://www.kdheks.gov/brfss/
    b. Kansas Health Matters: http://www.kansashealthmatters.org/
    c. Kansas Information for Communities: http://kic.kdheks.gov/
    d. United States Census Bureau: http://www.census.gov/en.html
2. Recruit schools and administer youth surveillance as requested.
3. Collect and submit local policies as requested.
4. For communities awarded CDSME funding, use of the Compass database will be required for entering data from workshop forms.

Communications and Promotion Activities

1. Integrate Kansas Tobacco Quitline and Brief Tobacco Intervention promotion into tobacco control activities.
2. If you perform paid media activities (paid advertisements in newspapers, billboards or paid content on social media), input the information into Catalyst.
3. Capitalize on local interventions, national reports/ data releases and current events to generate at least four instances of earned media.
4. Perform at least two public relations efforts geared toward specific groups of the public and decision-makers, and send informational letters to state legislators twice a year. Additional efforts could include speaking engagements/presentations.
5. Complete one success story per approved program area per year: one for tobacco, one for PAN and one for CDSME, if applicable. Use the Success Story form.

Partnership Activities

1. Create and/or maintain a diverse chronic disease prevention/health promotion coalition, with representation from targeted priority populations, that meets at least quarterly
2. Create and/or maintain a community coalition or a subcommittee of a larger community health coalition that focuses on **tobacco strategies** and that meets at least quarterly
3. Complete CDRR Coalition Assessment to improve coalition planning and function.

Eligibility

Eligible applicants are local health departments, which are expected to serve as the project lead on behalf of the community. A local health department may designate a partner organization to serve as the lead agency. If a partner organization is to serve as the lead agency, the application must include a letter from the local health department stating that it has designated another agency to be the applicant. A consortium of counties may apply together under one application.

Organizations within counties designated as target sites for the "State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke" grant (DP14-1422) are eligible for PAN funding from CDRR. However, applicants must demonstrate how 1422 and CDRR work will be integrated, how duplication will be avoided and how funds will be leveraged if PAN funds are requested.

Match

All applicants must provide a minimum of 25 percent match for every dollar awarded. The 25 percent match may be in cash, in-kind or a combination of both from county and/or public and private sources. Sources of in-kind match may include: school wellness funding, Safe Routes to School, Kansas Health Foundation and Sunflower Foundation Trails grant, Kansas Department of Transportation Enhancement grant and others as determined by the program director. Local funds that support existing evidence-based cessation program services and local funds provided for enforcement activities may also serve as local match. Please consult your Community Health Specialist for assistance in determining the amount of cash match required for a specific program. The applicant must document all costs used to satisfy the matching requirements. Program resources may be used for consultants, staff, survey design and implementation, data analysis, or other expenses associated with surveillance and evaluation efforts to fulfill the match requirement.

Available Funding and Budget

It is anticipated that approximately $1.5 million will be available to be awarded for FY18. Funding is contingent upon appropriations by the Kansas State legislature (Master Settlement aka Children's Initiative Fund) and the Centers for Disease Control and Prevention. Awards are competitive and requests typically exceed available funds. Funding decisions are based on application score, demonstration of need, appropriate expenses, population size, strength plan and applicant's ability to address health equity.

The budget should be entered into Catalyst with detailed budget item descriptions. For each staff member, describe the person's role and responsibilities. The CDRR form "Salary Worksheet" should be completed and attached to your CDRR Catalyst budget. The "Salary Worksheet" is available for download within Catalyst.

Funds may be used for reasonable costs associated with the program's activities including:

- salary
- travel
- registration fees

- supplies
- advertising, signage (requires prior approval from the Communication Coordinator to ensure statewide coordination)
- consultation
- facility rental
- equipment rental
- speakers/presenters
- educational materials

Grant Funds may **NOT** be used to:

- provide meals or snacks
- provide direct services, individual or group cessation services
- provide direct patient care or rehabilitation
- provide personal health services medications (NRT therapy)
- supplant existing funding from Federal, State, or private sources
- directly enforce policies
- pay for an internship
- provide incentives and promotional items
- provide staff time for direct classroom instruction of students of any age
- lobby government entities, or defray other costs associated with the treatment of diseases
- purchase capital equipment

Communities are encouraged to request partner contributions for food, which may be used as matching funds. The Kansas Department of Health and Environment funds cannot be used to supplant existing funding from Federal, State or private sources.

Review Procedures

Applications will initially be reviewed for completeness and responsiveness (Appendix B). Incomplete applications and applications that do not meet the eligibility criteria will not advance for further review. Applicants will be notified if their applications did not meet eligibility or published submission requirements.

Community Health Promotion staff may respond to questions regarding application processes, however, to provide an equitable and fair process to all applicants, staff will not respond to questions regarding application content. Community Health Promotion staff will not read the application prior to submission. Grant applications will be reviewed by a team of external and internal reviewers. The applicant organization's performance and compliance as a CDRR grantee during the past two fiscal years will be considered and discussed when scoring and ranking grant applications. Planning Grants will be scored separately to eliminate competition barriers for new applicants.

Award Administration Information - Chosen applicants will receive a Letter of Award and Grant Contract from the Kansas Department of Health and Environment. The first disbursement of grant funds may be expected on or before July 31, 2017. Any requested revisions to program activities, evaluation and/or budgets must be completed before the second disbursement of grant funds. Grant activities will be expected to start on July 1, 2017 and continue through June 30, 2018.

Grant Timeline

March	April	May	June	July	August
March 15, CDRR Grant application due	Review period	Award notices sent		July 1, Grant year begins, 25% of award funds distributed	
September	**October**	**November**	**December**	**January**	**February**
September 1, revisions due	October 1, 25% of award funds distributed		Site Visit	January 1, 12.5% of award funds distributed January 15, mid-year report and affidavit of expenditures due	February 15, 12.5% of award funds distributed
March	**April**	**May**	**June**	**July**	
	April 1, final 25% of award funds distributed	Site Visit	June 30, Grant year ends	July 15, end of year report and final affidavit of expenditures due	

CHRONIC DISEASE RISK REDUCTION GOAL AREAS

The following section describes the goal/content areas covered in CDRR that will have the greatest impact to prevent chronic disease, including: tobacco use prevention and dependence treatment; access to healthy foods and physical activity opportunities, including community design strategies; and chronic disease self-management education programs.

Communities are encouraged to think about the community as a whole with synergy across strategies, include non-traditional partners in the planning and implementation, and target only those populations most disproportionately impacted by chronic disease and the lifestyle behaviors that lead to chronic disease. Applicants are encouraged to propose innovative solutions to prevent chronic disease at the population level while keeping in mind evidence-based strategies and best practices focused on policy, systems and environmental change for greatest impact and sustainability.

NOTE: To be funded for CDRR, at least one tobacco workplan under Goal Area 1 or 2 must be selected. Goal Areas 3-5 are optional. Grantees are encouraged to select 1-5 high impact workplans to increase success.

GOAL AREA 1 (D.1): PREVENT INITIATION OF TOBACCO USE AMONG YOUNG PEOPLE

The 2012 Surgeon General's Report shows that 99% of smokers begin smoking and using other forms of tobacco by age 26; limiting exposure and access is a key strategy to prevent tobacco use. Engagement of youth in tobacco control involves providing the opportunity for young people to gain the ability and authority to make decisions that help improve the policy environment, change social norms, and reduce smoking initiation and consumption in their communities.

Implementing comprehensive smoke-free school policies can benefit young people from all racial/ethnic and socioeconomic backgrounds equally and is a good way to target social determinants of health related to

tobacco use to increase the quality of schools.[20] Comprehensive tobacco-free policies prohibit all forms of tobacco for students, staff, and visitors in school buildings, on school grounds and in school vehicles at all times. It is also recommended that comprehensive tobacco-free school policies prohibit tobacco use at off-campus school-sponsored events, add electronic cigarettes into the definition of prohibited products and prohibit tobacco industry sponsored materials (including tobacco clothing) and sponsorship. Opportunities to support cessation can include the Kansas Tobacco Quitline and other local resources.

In the tobacco retail setting marketing, advertising, and promotional strategies have been especially heavily marketed to low-income, minority, and young adult populations, making them a specific target of the tobacco industry and creating communities that are disproportionately susceptible to tobacco use.[18] Research has also shown that lower-income communities have higher amounts of tobacco advertising within 1,000 feet of schools compared to higher income communities, higher amounts of marketing and retailers impacts the amount of experimental smoking among students.[21] (44, 51, 53 Truth Article). Increase the minimum age of sale and purchase of tobacco products to 21 represent an opportunity for communities to further efforts to prevent initiation of tobacco use. A March 2015 Institute of Medicine study estimated that Tobacco 21 would reduce smoking among 15-17 year old by 25% and among 18-20 year olds by 15% nationally.

KEY RESOURCES:

- Best Practices User Guide; Youth Engagement- State and Community Interventions: http://stacks.cdc.gov/view/cdc/5628
- RESIST - The State Youth Tobacco Prevention Program: http://resisttobacco.org/
- The Toll of Tobacco in Kansas by the Campaign for Tobacco Free Kids: http://www.tobaccofreekids.org/facts_issues/toll_us/kansas
- Americans for Nonsmoker's Rights Resources: http://www.no-smoke.org/goingsmokefree.php?id=447
- The BACCHUS Initiatives of NASPA - supports collegiate peer educators and advisors by empowering students and student affairs administrators to create campus environments which are healthy and safe: http://www.naspa.org/constituent-groups/groups/bacchus-initiatives
- Johnson County Health Department-Tobacco-Free Schools Toolkit: http://tobaccofreekansas.org/user/file/Tobacco-Free%20Schools%20Toolkitfinal2011.pdf
- Tobacco-free College Campus Initiative: http://tobaccofreecampus.org/resources
- Counter Tobacco- Policy Solutions: http://www.countertobacco.org/policy/
- Counter Tobacco- Store Assessment Tools: http://www.countertobacco.org/resources-tools/store-assessment-tools/
- ChangeLab Solutions- Tobacco Retailer Licensing: http://www.changelabsolutions.org/publications/tobacco-retailer-licensing
- Tobacco21: www.tobacco21.org
- Policy Strategies: A Tobacco Control Guide: http://cphss.wustl.edu/Products/Documents/CPHSS_TCLC_2014_PolicyStrategies1.pdf
- Public Health Law Center- Tobacco Control: http://www.publichealthlawcenter.org/topics/tobacco-control

[20] Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015.

[21] Truth Initiative. Achieving Health Equity in Tobacco Control. December 8, 2015.

Strategy D.1.1. Increase the number of school districts and colleges/universities implementing 100% tobacco-free policies

Workplan D.1.1.1. Increase the number of schools or school districts with 100% tobacco-free policies and plan for enforcement

Required Work Plan Performance Measures:

1. Number of school age youth who participate in tobacco-use prevention activities
2. Proportion of schools or school districts with comprehensive[22] tobacco-free school grounds policies (provide both the total number of schools or school districts and the number of schools or school districts with comprehensive tobacco-free policies).
3. Proportion of school aged youth enrolled in a school or school district with comprehensive[21] tobacco-free school grounds policies policies (provide both the total number of school age youth enrolled in schools or school districts and the number of students enrolled in schools or school districts with comprehensive tobacco-free policies).

Workplan D.1.1.2. Increase the number of colleges/universities with 100% tobacco-free policies and plan for enforcement

Required Performance Measures:

1. Number of college or university students who participate in tobacco-use prevention activities
2. Proportion of post-secondary institutions with 100% tobacco-free or smoke-free college campus policies (provide both the total number of post-secondary institutions and the number of post-secondary institutions with smoke-free/tobacco-free campus policies).
3. Number of students and staff protected by a 100% tobacco-free or smoke-free college campus policy

Strategy D.1.2. Increase the number of policies that restrict minors' access to tobacco products

Workplan D.1.2.1. Increase the number of communities that adopt, strengthen and enforce policies that restrict youth access to tobacco products.

Required Performance Measures:

1. Number of youth who participate in retail-related strategies for tobacco use prevention
2. Number of policies passed that restrict youth access to tobacco products, including restrictions on flavored tobacco products, proximity of retailer to a school, or age of purchase.

GOAL AREA 2 (D.2): ELIMINATE NONSMOKERS' EXPOSURE TO SECONDHAND SMOKE

According to the Centers for Disease Control and Prevention (CDC), there is no risk-free level of exposure to tobacco smoke, including secondhand smoke; even brief exposure can be harmful to health. In the United

[22] Comprehensive tobacco-free policy for school districts are policies that prohibit the use of all tobacco products by anyone (including students, staff and visitors) on school property or at school events at all times. School property means all property whether owned, leased, rented or otherwise used by a school and includes buildings, grounds and vehicles.

States, it is estimated that 1 in 4 nonsmokers are exposed to secondhand smoke, and 2 in 5 children are exposed to secondhand smoke. For black children, those numbers are 7 in 10.[23]

In multi-unit housing facilities, smoke-free policies can play an important role in protecting residents, especially children, from secondhand smoke (SHS) and preventing fires. These policies protect residents from risks of developing heart disease, stroke, and lung cancer in adults, and Sudden Infant Death Syndrome (SIDS), lung problems, ear infections, and asthma attacks among children and babies.[23]

A key component of health equity work in tobacco control is eliminating secondhand smoke exposure disparities between groups.[24] Comprehensive tobacco control policies that are well-enforced help to reduce tobacco related disparities. Policies to reduce secondhand smoke exposure include comprehensive smokefree policies in multi-unit housing, parks and outdoor areas, and in worksites. It is important to protect all population groups and not include exceptions or loopholes in policies that might leave some groups exposed.

KEY RESOURCES

- Americans for Nonsmokers' Rights- Resources & Tools for Smokefree Multi-Family Housing: http://www.no-smoke.org/pdf/MUHresources.pdf
- Americans for Nonsmokers' Rights- Getting Started on Smokefree Multi-Family Housing: http://www.no-smoke.org/pdf/MUHgettingstarted.pdf
- CDC: Going SmokeFree Matters Multiunit Housing: https://www.cdc.gov/tobacco/infographics/policy/pdfs/going-smokefree-matters-multiunit-housing-infographic.pdf
- HUD: Smoke-free Housing Toolkit for Owners/Management Agents: http://portal.hud.gov/hudportal/documents/huddoc?id=pdfowners.pdf
- HUD: Public Housing Authority Contacts: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/pha/contacts/ks#footnote
- Tobacco Free Wichita Smoke-Free Housing Initiative: https://tobaccofreewichita.org/smoke-free-housing-initiative/
- Public Health Law Center Smoke-free & Tobacco-free Places (Housing, Outdoors, Schools, Workplaces): http://publichealthlawcenter.org/topics/tobacco-control/smoke-free-tobacco-free-places
- The American Cancer Society-Tobacco-Free Workplace Toolkit: http://www.cancer.org/downloads/gahc/tobaccofree_workplacetoolkit_2009.pdf
- Change Lab Solutions Smokefree Parks: http://changelabsolutions.org/sites/default/files/documents/Smokefree_parks_FINAL_20110816.pdf
- Utah Tobacco-Free Workplace Toolkit: http://www.tobaccofreeutah.org/pdfs/shsworksitekit.pdf
- Tobacco-free Parks: http://www.tobaccofreeparks.org/documents/Creating_Healthy_Communities.pdf
- Young Lungs at Play: http://www.coginc.org/Resources/04-%20YLAP%20Fact%20Sheet.pdf
- Policy Strategies: A Tobacco Control Guide: http://cphss.wustl.edu/Products/Documents/CPHSS_TCLC_2014_PolicyStrategies1.pdf
- Public Health Law Center- Tobacco Control: http://www.publichealthlawcenter.org/topics/tobacco-control

[23] CDC, Going Smoke-Free Matters, https://www.cdc.gov/tobacco/infographics/policy/pdfs/going-smokefree-matters-multiunit-housing-infographic.pdf

[24] Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2015. https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf

Strategy D.2.1. Increase policies for smoke-free multi-unit housing

Workplan D.2.1.1. Increase the number of multi-unit dwellings with smoke-free policies in combination with cessation support

Required Performance Measures:

1. Proportion of multi-unit housing complexes with 100% smoke-free in all units, including balconies and patios where applicable. Provide both the total number of multi-unit housing complexes and the number of number of muli-unit housing complexes with 100% smoke-free policies in all units.
2. Proportion of multi-unit housing complexes with partial smoke-free policies. Partial smoke-free policies include apartment complexes that have smoke-free units but policies do not cover 100% of all units (i.e. only some buildings or sections of buildings have smoke-free units). Provide both the total number of multi-unit housing complexes and the number of number of multi-unit housing complexes with partial smoke-free policies.
3. Proportion of units covered by smoke-free policies in multi-unit housing complexes. Provide both the total number of units and the number of units covered by smoke-free policies.
4. Proportion of multi-unit housing residents covered by smoke-free policies. Provide both the total number of multi-unit housing residents and the number of multi-unit housing residents covered by smoke-free policies.

Strategy D.2.2. Increase the number of locations with tobacco-free policies

Workplan D.2.2.1. Increase the number of tobacco-free policies in worksites, in combination with cessation and enforcement support, with a focus on low wage worksites and in locations serving low SES communities and racial and ethnic subgroups.

Required Performance Measures:

1. Number of new tobacco-free policies adopted in worksites.
2. Proportion of targeted employers in city/county implementing a new worksite tobacco-free policy.
3. Proportion of employees impacted by implementation of a a new worksite tobacco-free policy.

Workplan D.2.2.2. Increase the number of tobacco-free policies in settings where people gather, e.g.: parks, trails, farmers markets, sports arenas and outdoor work areas

Required Performance Measures:

1. Proportion of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies (provide both the total number of city/county parks/recreation sites and the number of city/county parks/recreation sites that currently have smoke-free/tobacco-free policies).

GOAL AREA 3 (D.3): PROMOTE QUITTING AMONG ADULTS AND YOUNG PEOPLE

NOTE: Promotion of the "Brief Tobacco Intervention" (BTI) web-based training to local providers must be incorporated into the workplan(s) that you choose in this Goal Area 3. A brief description of the BTI web-based training can be found in the key resources section.

Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence (Fiore MC, May 2008). More than 80% of smokers see a physician every year, and most smokers want and expect their physicians to talk to them about quitting smoking and are receptive to their physicians' advice (CDC Best Practices 2014). "The Clinical Practice Guideline: Treating Tobacco Use and Dependence" recommends providing tobacco users information on quitting techniques, pharmacotherapies and cessation counseling.

KEY RESOURCES:

- Brief Tobacco Intervention Online Training: www.kstobaccointervention.org.
- The Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update: https://www.ncbi.nlm.nih.gov/books/NBK63952/
- Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic (a free interactive multimedia program based on the "Virtual Practicum" model): www.smokingcessationandpregnancy.org.
- Dimensions: Tobacco-free Toolkit for Healthcare Providers: http://www.bhwellness.org/toolkits/Tobacco-Free-Toolkit.pdf
- A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment: https://www.cdc.gov/TOBACCO/quit_smoking/cessation/pdfs/practical_guide.pdf
- Action to Quit: Advancing Tobacco Control Policy (in Hospitals): http://actiontoquit.org/our-work/health-care/hospitals/
- Help Your Patients Quit Tobacco Use: An Implementation Guide for Community Health Centers: http://www.smokefreeoregon.com/wp-content/uploads/2011/01/LEG-Community-Health-Report-Inside-Final-10-11-13.pdf
- Smoking Cessation Leadership Center Toolkits: https://smokingcessationleadership.ucsf.edu/behavioral-health/resources/toolkits

Strategy D.3.1. Increase the engagement of health care providers and systems to expand utilization of proven cessation services

Workplan D.3.1.1. Promote adoption of the *Kansas Tobacco Guideline for Behavioral Health Care* by behavioral health care facilities.*

Required Performance Measures:

1. Number of facilities that adopt the *Kansas Tobacco Guideline for Behavioral Health Care*.
2. Number of facilities that establish a new policy, systems or environment change that includes the KDHE "Brief Tobacco Intervention" web-based provider training.
3. Number of behavioral health providers in target locations who complete the KDHE "Brief Tobacco Intervention" web-based provider training.
4. Number of individuals referred to the Kansas Tobacco Quitline phone or web based service by a healthcare professional.

Workplan D.3.1.2. Establish tobacco dependence screening, referral and treatment systems within Federally Qualified Healthcare Centers (FQHC's).

Required Performance Measures:

1. Number of FQHC's that establish a systems change to adopt or improve tobacco dependence treatment including screening, referring and providing brief tobacco dependence treatment.
2. Number of FQHC providers who complete the KDHE "Brief Tobacco Intervention" web-based provider training.

Workplan D.3.1.3. Establish tobacco cessation screening, referral and counseling systems targeting healthcare providers serving women during the perinatal period. Target locations: local health departments and safety net clinics serving women during the perinatal period. Interventions to include: pilot testing the KanQuit online enrollment using a "warm handoff" model in WIC clinics in at least one county; and coordinating local professional development opportunities to healthcare providers on clinical best practices for cessation before, during and after pregnancy.

Required Performance Measures:

1. Number of health care provider organizations that establish a systems change to adopt or improve practices for tobacco dependence treatment during pregnancy including screening, referring and providing brief tobacco dependence treatment.
2. Number of healthcare provider organizations that establish a new policy, systems or environment change that includes the KDHE "Brief Tobacco Intervention" web-based provider training.
3. Number of healthcare providers in target locations who complete the KDHE "Brief Tobacco Intervention" web-based provider training.
4. Number of women who are currently pregnant, planning pregnancy or currently breastfeeding who enroll in the Kansas Tobacco Quitline.

***Communities funded for D.3.1.1 may be eligible for funding to cover the costs of up to 5 behavioral health provider to complete the Tobacco Treatment Specialist Training through UMass (up to $10,000) OR to host KU Medical Center TTS training on-location (up to $20,000).**

GOAL AREA 4 (D.4): INCREASE PHYSICAL ACTIVITY, ACCESS TO HEALTHY FOODS, AND COMMUNITY RESILIENCY

Physical inactivity and poor nutrition are two of the three main risk factors leading to multiple chronic diseases, including heart disease, stroke, and some cancers. Whether or not people engage in physical activity and healthy diets is the result of many factors, including culture, socioeconomic status, and the built environment. Disparities in health outcomes among different populations are exacerbated by policy and environmental barriers to healthy food and physical activity access. Increasing physical activity and nutrition, and decreasing the prevalence of chronic diseases, requires a coordinated and comprehensive approach that engages underserved populations in identifying needs and solutions, works with and through diverse sectors and partners in the community, and implements policies, plans and environments supportive of healthy food and physical activity access, especially for underserved populations.

KEY RESOURCES:

- The Case for Healthy Places: Improving Health Outcomes through Placemaking: https://www.pps.org/wp-content/uploads/2016/12/Healthy-Places-PPS.pdf
- Public Health Law Center-Kansas Resources: http://publichealthlawcenter.org/topics/special-collections/kansas-resources
- Smart Growth America: http://www.smartgrowthamerica.org/
- Dietary Guidelines 2015-2020: http://health.gov/dietaryguidelines/2015/guidelines/
- WorkWell Kansas: http://www.workwellks.com/
- USDA Food and Nutrition Service: http://www.fns.usda.gov/ebt/learn-about-snap-benefits-farmers-markets
- MarketLink (free EBT equipment): http://marketlink.org/
- Farmers Market Coalition (free EBT equipment): https://farmersmarketcoalition.org/
- From the Land of Kansas: https://fromthelandofkansas.com/explore-from-land-kansas
- USDA Local Food Directories: http://www.ams.usda.gov/local-food-directories/farmersmarkets
- National Farm-to-School Network-Kansas: www.farmtoschool.org/our-network/Kansas
- Safe Routes to School: http://www.saferoutesinfo.org/

Strategy D.4.1: Increase support for policies and programs that expand access to healthy foods and opportunities for physical activity in worksite and community settings

Workplan D.4.1.1: Establish new food policy councils and/or implement one to two food policy council priorities that advance policy, system, and environmental changes to support a healthy food system and improved food access, especially among undeserved populations at a higher risk for chronic diseases.

Required Performance Measures (include performance measures that align with selected approaches for D.4.1.1):

1. If the workplan involves establishing new food policy council(s) report: Number of jurisdictions covered by newly formed food policy councils.
2. Number and type of food council priorities implemented that advance policy, system and environmental change to support healthy food system and food access.
3. Number of adults impacted by the food council priorities implemented that advance policy, system and environmental change to support healthy food system and food access.

Workplan D.4.1.2: Incorporate healthy food and physical activity access into community comprehensive plans that are new or due to be updated, with a focus on equitable access for underserved populations at a higher risk for chronic diseases.

Required Performance Measures:

1. Number of municipalities with new or updated community comprehensive plans that include healthy food and/or physical activity access, with a focus on equitable access to underserved populations.
2. Number of people in jurisdictions covered by new or updated community comprehensive plans that include healthy food and/or physical activity access, with a focus on equitable access to underserved populations.

Workplan D.4.1.3: Promote the adoption of food service guidelines/nutrition standards that also include sodium with a focus on underserved populations at a higher risk for chronic diseases. Target locations may

include venues where food is provided or sold including, but not limited to, worksites, hospitals, schools and/or community vending, cafeterias, snack bars and meetings or events (e.g. conferences).

Required Performance Measures:

1. Number of community settings and/or worksites that develop and/or adopt policies to implement food service guidelines/nutrition standards, including sodium. Report community settings and worksites separately.
2. Number of persons and/or employees who access community settings and/or worksites that have developed and/or adopted policies to implement food service guidelines/nutrition standards, including sodium. Report number of persons impacted by community settings and employees impacted by worksites separately.

Workplan D.4.1.4: Promote the adoption of physical activity policies and practices in worksite settings, especially in worksites that employ underserved populations at a greater risk for chronic diseases.

Required Performance Measures:

1. Number of worksites that adopt policies or practices to increase physical activity.
2. Number of employees who work in worksites that adopt policies or practices to increase physical activity.

Workplan D.4.1.5: Establish new, and expand existing, farmers markets, including the promotion and support of access to and use of EBTs-SNAP and SFMNP at farmers markets.

Required Performance Measures:

1. Number of farmers markets serving the community who are registered with USDA and From the Land of Kansas
2. Number of farmers markets serving the community that accept federal or state nutrition assistance benefits programs (SNAP, SFMNP) as tracked in the USDA and From the Land of Kansas directories
3. Number of farmers markets serving community that offer match dollars for nutrition assistance benefits programs (SNAP, SFMNP)
4. Number of farmers markets serving community that implement new infrastructure improvements (e.g. EBT machines, reusable tokens, establishing bylaws or official market rules, funding a paid manager or staff position, improved physical infrastructure (handwashing station, pavilion, expanded parking), improved public transportation options to market, permanent promotional materials (banners, signage, tents with logos)).
5. If workplan includes expanding existing markets, grantee **must** propose 1 to 3 additional performance measures that demonstrates impact of expansion (e.g. number of vendors added to a market, increases in foot traffic, SNAP/EBT revenue, number of vendors certified to accept SNAP/EBT/SFMNP).

Strategy D.4.2: Create safe and walkable communities that are distinctive, attractive, and foster a strong sense of place

Workplan D.4.2.1: Adopt and/or implement/enforce Complete Streets or equivalent policies (e.g. joint use agreement, Safe Routes to School) in combination with inclusive and culturally competent community engagement and awareness activities

Required Performance Measures:

1. Number of municipalities that develop new or enhance existing Complete Streets or equivalent policies **(e.g. joint use agreement, Safe Routes to School)** that include walking
2. Number of residents in a jurisdiction with Complete Streets or equivalent policies **(e.g. joint use agreement, Safe Routes to School)** that include walking

Workplan D.4.2.2: Adopt and/or implement/enforce master bike/walk transportation plans, master park plans, and/or master trail plans in combination with inclusive and culturally competent community engagement and awareness activities

Required Performance Measures:

1. Number of municipalities that develop and/or adopt new master bike/walk transportation plans, master park plans, and/or master trail plans or enhance existing plans
2. Number of residents in a jurisdiction with new or enhanced master bike/walk transportation plans, master park plans, and/or master trail plans that are developed and/or adopted.
3. Number and type of inclusive and culturally competent community engagement and awareness activities.

Workplan D.4.2.3: Form or strengthen bike/walk planning advisory committees with representation from and engagement of diverse and underserved populations at a higher risk for chronic diseases to coordinate local community design policy efforts and awareness activities

Required Performance Measures:

1. Number of municipalities where new bike/walk planning advisory committees are adopted
2. Number and type of organizations represented on bike/walk planning advisory committees
3. Number of policies enacted that include language that supports environmental changes to enhance places for physical activity, emphasizing walking

Workplan D.4.2.4: Adopt and/or implement community-wide and/or district-specific design standards to increase active transportation and access to services and resources, especially among underserved populations at a higher risk for chronic diseases. Combine with culturally competent community engagement and awareness activities.

Required Performance Measures:

1. Number and type (community-wide or site-specific) design standards that are adopted and/or implemented to increase active transportation and access to services and resources, especially among underserved populations at a higher risk for chronic diseases.
2. For Community-Wide Design Standards: Number of residents in a jurisdiction with community-wide design standards that are adopted and/or implemented to increase active transportation and access to services and resources, especially among underserved populations at a higher risk for chronic diseases.
3. For District-Specific Design Standards: Number of residents within a one quarter-mile radius buffer around the district(s) that adopt and/or implement district-specific design standards to increase active transportation and access to services and resources, especially among underserved populations at a higher risk for chronic diseases.
4. Number and type of inclusive and culturally competent community engagement and awareness activities.

Strategy D.4.3: Increase community resiliency

Workplan D.4.3.1: Develop and implement a Creative Place-making Plan in partnership with local artists and community groups, especially those from underrepresented populations, to create culturally-relevant, vibrant places to live and work.

Required Performance Measures:

1. Number of Creative Place-making Plans developed and/or implemented.
2. Number and type of community partners engaged in development and implementation of Creative Place-making Plan(s).

Workplan D.4.3.2: Repurpose existing infrastructure and vacant properties in culturally-relevant ways to increase community health, resiliency, and economic diversification. Work in partnership with property owners, Chambers of Commerce, local government officials, underrepresented community groups, and small business and start-up business owners.

Required Performance Measures:

1. Number and type of existing infrastructure or vacant properties acquired for repurposing.
2. Number of acquired infrastructure or vacant properties repurposed. Also describe new purpose (e.g. fitness facility, community center, food market, pop-up shop or other economic incubator)
3. Number and type of community and business partners engaged in acquiring and repurposing existing infrastructure or vacant properties.

GOAL AREA 5 (D.5): INCREASE THE ABILITY OF THOSE WITH CHRONIC DISEASE TO MANAGE THEIR CONDITION(S)

Chronic Disease Self-Management Education programs are evidence-based curricula developed by Stanford University. KDHE is one of two license-holders in Kansas to implement these programs. Workshops are once a week for six weeks and led by two trained leaders, one of whom is living with a chronic condition. Workshops are recommended for anyone living with one or more chronic conditions, family or friends of those living with a chronic condition as well as caregivers. These interactive workshops provide participants with techniques to deal with symptoms such as pain, fatigue and depression associated with chronic conditions. Participants also learn and practice problem-solving and action planning.

Stanford Patient Education: http://patienteducation.stanford.edu/programs/cdsmp.html
Kansas Department of Health and Environment, Tools for Better Health: www.ToolsForBetterHealthKS.org
Note: Media material must include the KDHE logo to comply with the Stanford licensing guidelines. All media material must be sent to and approved by KDHE before distributing.

Strategy D.5.1: Increase access to Chronic Disease Self-Management Education (CDSME) programming

Workplan D.5.1.1: Promote and coordinate the expansion of CDSME programming opportunities and their reach

Required Performance Measures:

1. Number of organizations coordinating and implementing one or more CDSME program consistently (i.e. two or more CDSMP workshops per year)
2. Number of community organizations referring to workshops (include names of community organizations).
3. Number of providers referring to workshops through a trackable referral system (a trackable referral system includes systems, such as Electronic Health Records or the KDHE bi-directional referral process, that allow providers to track when referrals are sent and if referred patients attended and/or complete the CDSME program).

Required Action Steps: Identify a local CDSME program coordinator. Coordinator will:

1. Provide TA to local leaders and organizations while they coordinate and implement workshops.
2. Assist in marketing/promotion efforts (e.g. distribute educational materials to recruit participants, leverage earned media to recruit partner organizations and participants)
3. Ensure data from workshop forms is entered into **Compass database**, assist leaders with collection of workshop forms and and submission of forms to the Kansas Foundation for Medical Care.
4. Engage **one or more organizations** to commit to being delivery-system partners who will work to implement and coordinate CDSME workshops two or more times a year, and is willing to have a CDSME Champion within that organization to coordinate CDSME efforts.
5. Work with KDHE CDSME Coordinator to identify and recruit **one or more healthcare providers** as referral partners.
6. Identify **one or more persons** to attend Fidelity Check Training online or in person. This training will equip identified person(s) to visit all local leaders at one workshop per year to support them and ensure Stanford fidelity guidelines are being upheld.

Application Instructions

Incomplete applications will not be considered. Please use the application checklist provide in Appendix A.

Please direct any questions to your regional Community Health Specialist. Grantees are encouraged to have assigned Community Health Specialist review application at least 48 hours prior to submission to ensure application is complete. An application checklist is included.

To apply, applicants must procure an account with Catalyst (http://www.catalystserver.com; info@catalystserver.com). Login to http://www.CatalystServer.com, apply for CDRR funding, remove and/or add optional workplan items, fill in requested information and attach the below completed supplemental forms to the CDRR budget in Catalyst.

Applications will be scored by a team of internal and external reviewers. Score weight is listed in each section below. In addition, applicants will be scored on grammar, content organization, completeness and conciseness worth a total of 5 points. Funding decisions will also be based on past performance and progress, if this funded in the previous year.

General budget and required fields in Sections A and D of Catalyst:

A. Budget (Main page of CDRR application):

a. General Budget (located on main page of CDRR Application):

i. Complete the budget line items within Catalyst providing the necessary financial information in the following categories:

1. Salary/Personnel
2. Benefits
3. Supplies
4. Travel
5. Paid Media
6. Other (e.g. sub-contractors)

ii. Provide a complete description of staff responsibilities and justification for expenditures on staff worksheet.

B. Administration and Management-Category-A.1 (Capacity Building and Accountability)

a. Required fields to be completed:

i. Community Profile and Statement of Need

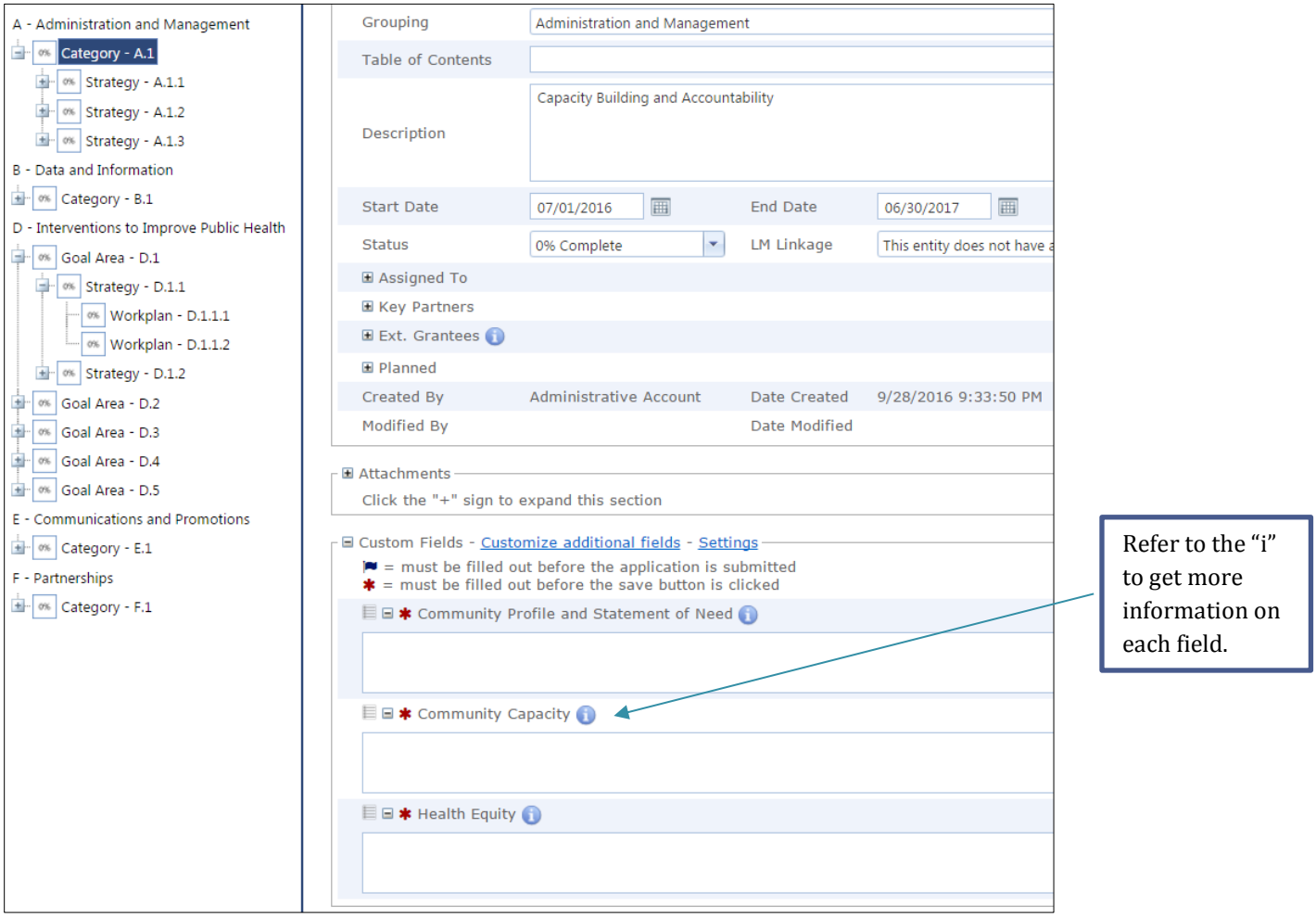
- Provide a clear and specific description of the community that includes data on community demographics and the prevalence of behaviors and/or chronic diseases
- Provide a clear and full explanation of how the funds will benefit the community through the selected work plans.

ii. Community Capacity

- Describe plan for staff, partnership collaboration, resources, and necessary training and tools needed to support the work plans.

iii. Health Equity

- Provide details on community plan for engaging and impacting populations experiencing preventable health inequities and how your community will work to advance health equity community wide.



D. Interventions to Improve Public Health – Workplans D.1.1.1-D.5.1.3 (depending on which workplans are selected)

a) Required Fields for each workplan selected:

i. Multi-year SMART Objective

- Multi-year Objective must be SMART - Specific, Measurable, Achievable and Time-bound.
- The multi-year objective will lead to progress on required performance measures and be clearly tied to the workplan.
- SMART format: "By [date], increase or decrease [y] to [x]."

ii. Annual SMART Objective

- Annual Objective must be SMART - Specific, Measurable, Achievable and Time-bound.
- The annual objective should ultimately lead to progress on multi-year objective and required performance measures.

iii. Target Population

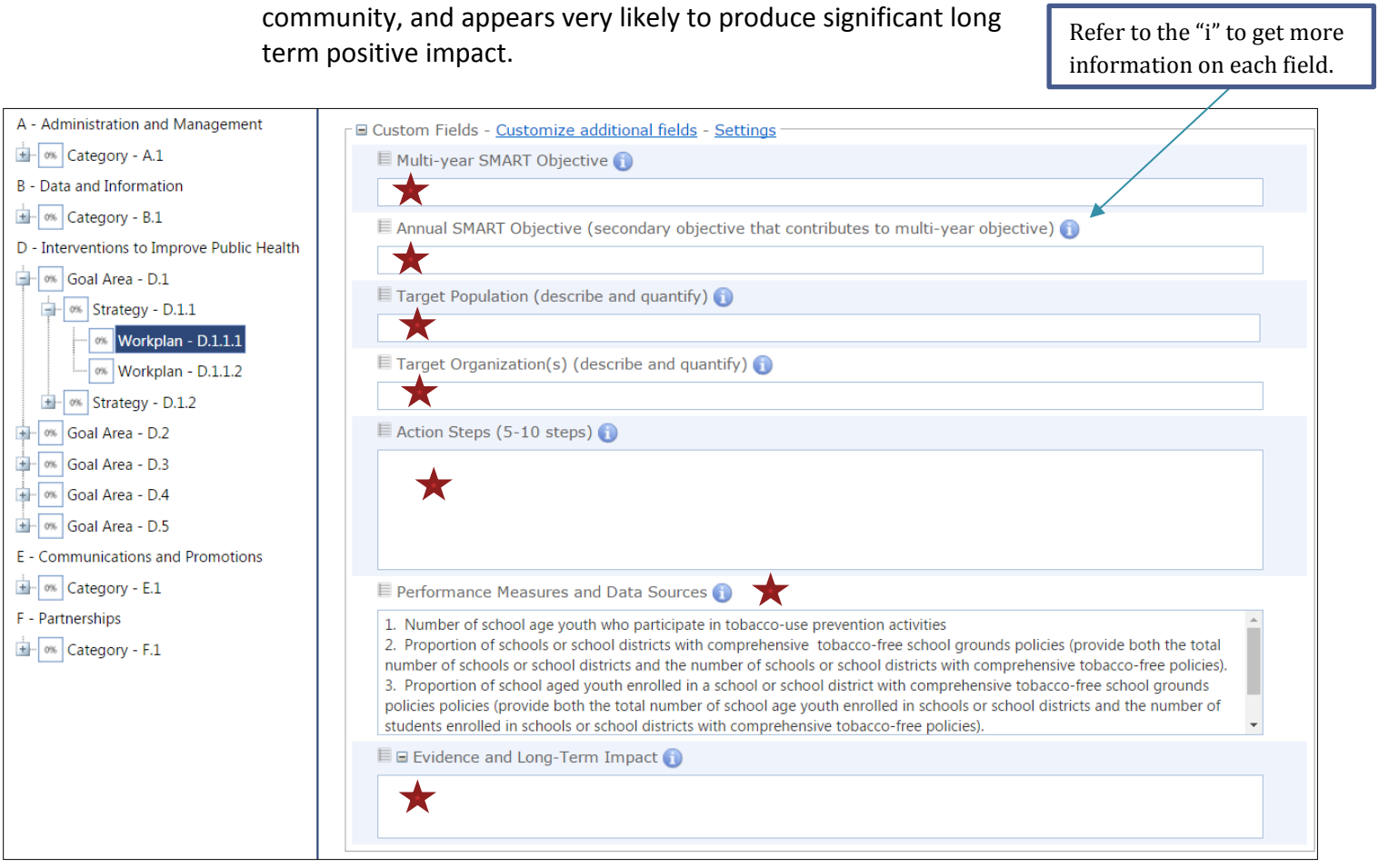
- Describe and quantify the group of people this activity will help.

iv. Target Organization
- List organizations this activity will impact. If you plan to help students, then the organization would be the schools you plan to work with. If you want to work with employees, then the organization would be their employer.Action Steps

v. Action steps (5-10 Steps)
- Action steps are purposeful, logical and will lead to significant progress on objectives.
- Action steps for CDSME are pre-populated; no additional action steps need to be added.

vi. Performance Measures and Data Sources
- Required performance measures for each workplan are auto-filled in Catalyst. Include data sources that will be used to address the required performance measures in parenthesis after each performance measure.
- Where applicable, applicants are encouraged to include a limited number of additional quantitative measures to evaluate progress towards reaching the annual objective and required performance measures. Focus on 1 to 3 important measures. Consider including a measure that addresses how underserved populations are engaged or reached.

vii. Evidence and Long-Term Impact
- Describe how work plan is evidence based, linked to sustainable policy, systems or environmental changes, shows synergy with other work in the community, and appears very likely to produce significant long term positive impact.



Required Forms (completed separately and uploaded into Catalyst in attachment section.

Applicants must complete the following forms: Coalition Membership Form (for Implementation Phase applicants not Planning) **OR** Planning Phase Form (for Planning Phase applicants); Communications Worksheet; and the Salary Worksheet. Forms are to be attached on the main page of your Catalyst application.

1. **Coalition Membership Form (Implementation Phase applicants ONLY):**
    a. Clearly identify and provide evidence of an active and diverse community coalition.
        i. Sectors of community support are provided as a guideline for composition of an optimal community coalition for chronic disease risk reduction.
        ii. Applicants are encouraged, but are not required to have an organization represented in every sector.
        iii. Applicants should include all sectors with direct relevance to selected goals and outcomes. Each sector may have multiple participants.
2. **Planning Phase Form (Planning Phase applicants ONLY):**
    a. List current connections with different organizations, associations and Sectors in your Community using the *Connections Map* section
    b. Identify existing community priorities and the groups that are working on those priorities in the *Identifying Linkages Between Community Priories and Tobacco Control* section
    c. Identify existing community priorities and the groups that are working on those priorities in the *Identifying Linkages Between Community Priories and Physical Activity and Nutrition* section
    d. Provide information on types and levels of partnerships that will be pursued in the *Types and Levels of Partnership* section
3. **Communications Worksheet:**
    a. Provide a clear, complete and detailed description of proposed communications activities.
        i. Briefly explain how you will use Kansas Tobacco Quitline materials in each of the tobacco workplans you choose.
        ii. If applicable, briefly describe your planned paid media (e.g. advertisements).
        iii. Briefly explain how you plan to leverage local interventions and coalition activities to pursue earned media coverage.
        iv. Provide at least four examples of earned media efforts that you will do during the year such as pitching stories to a reporter, sending a news release, writing a letter to the editor, obtaining shares on social media to pursue earned media coverage.
        v. Briefly describe the specific members of the public or groups you plan to target.
        vi. Briefly describe which public relations activities you plan to utilize such as speaking engagements, one-on-one meetings, phone calls, letters, fact sheets, PowerPoint presentations, or other printed and electronic materials.
4. **Salary Worksheet:**
    a. List the employee name and title for each proposed staff member.
    b. Indicate the total number of hours per week for each staff member and the percentage of time spent on the CDRR grant.
    c. Indicate total salary for each staff person listed.
    d. Indicate time allocated to tobacco use prevention, physical activity and nutrition, and chronic disease self-management for each staff listed.
    e. Columns F and H will automatically populate based on information entered.
    f. No more than 10 percent of administrators' salaries may be funded by CDRR.

Appendix B: Chronic Disease Risk Reduction – Application Checklist

Please use this checklist and the scoring rubric to ensure your application is complete and meets expectations for a high quality application.

The following must be submitted as attachments in Catalyst by the application deadline:

___ CDRR Coalition Members Form (implementation applicant)
or CDRR Planning Phase Form (planning applicant)

___ CDRR Communications Worksheet

___ CDRR Salary Worksheet

___ Letter from local health department designating applicant agency (if applicable)

The following must be completed in Catalyst by the application deadline:

___ **A. Administration and Management, Category A.1**

___ Community Profile

___ Statement of Need

___ Community Capacity

___ Health Equity

___ **D. Interventions to Improve Public Health (for each selected work plan)**

___ Multi-year SMART Objective

___ Annual SMART Objective

___ Target Population

___ Target Organization(s)

___ Action Steps

___ Performance Measures and Data Source (Required performance measures auto-filled)

___ Evidence and Long-Term Impact

Appendix B: Scoring Guidance and Weights for Each Section

SFY 18 (2017-2018) CDRR Scoring Guidance

Administration and Management: Evidence that the organization has a need for and ability to successfully use the funds.		Score Weight
Community Profile	Clear and specific description of community that includes data on community demographics and the prevalence of behaviors and/or chronic diseases.	
Statement of Need	Clear and full explanation of how the funds will benefit the community through the selected work plans.	
Community Capacity	Staff, partnership collaboration, resources, and necessary training and tools are detailed and linked specifically to addressing community needs.	
Health Equity	Advancement of health equity is completely addressed, details a comprehensive plan for engaging underserved populations, and it appears likely the applicant will moderately advance health equity.	
Budget & Salary Worksheets	Detailed and realistic budget with clear justification of proposed expenditures for carrying out selected work plans.	40%
Communications and Promotions: Evidence that the organization has a plan for effectively communicating with the public and legislators.		
Communications Worksheet	Clear and detailed description of proposed communications activities and full completion of communications worksheet.	10%
Community Engagement: Evidence that the organization actively engages diverse community stakeholders and underserved populations.		
CDRR Coalition Member Form	Clearly identifies and provides evidence of active representation from diverse community stakeholders and sectors on community coalition.	5%
Application Quality: Evidence that the organization applied forethought, organization, and correct grammar to their application.		
Grammar and Content Organization	Exemplary grammar and content organization that is easy to read and comprehend, and has no or few minor errors.	
Completion and Conciseness	Provides complete and concise responses.	5%
Work Plans to Improve Public Health.		
Annual and Multi-Year SMART Objectives	Annual and multi-year objectives are SMART, realistic and achievable, and are likely to advance health equity.	
Action Steps	Action steps are logical, appear likely to lead to significant progress toward annual and multi-year SMART objectives, include actions to address health equity, and show coordination with partners.	
Performance Measures and Data Sources	Required performance measures are included. If additional qualitative measures are included, they are clear, and very likely to demonstrate progress. Data sources are included for all performance measures and are clearly described and appropriate.	
Evidence and Long-term Impact	Work plan is evidence based, linked to sustainable policy, systems or environmental changes, shows synergy with other work in the community, and appears very likely to produce significant long term positive impact.	40%
The total points from each workplan will be averaged.		